STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINERS
COUNCIL OF CERTIFIED PROFESSIONAL MIDWIFERY
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384
www.tennessee.gov

APPLICATION INSTRUCTIONS FOR CERTIFICATION AS A MIDWIFE
APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee certificate to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Council.**

		Done
1.	Complete, sign, have notarized, and mail the application pages 1 through 6.	_____
2.	Attach to the application a clear, recognizable, recently taken passport photograph of yourself.	_____
3.	If you are or have ever been licensed, certified, registered, or permitted by any state or country to practice as a Midwife or other health professional, you must complete and mail Attachment 1 to each and every state. Copies of Attachment 1 may be duplicated to accommodate each request.	_____
4.	Certification from NARM is a requirement. You must complete and mail Attachment 2 to the NARM office.	_____
5.	Submit two (2) <u>original</u> letters of recommendation from persons who can attest to your character as a Midwife. One (1) of the required letters shall be submitted from a health care professional. No letters from family members or relatives shall be accepted. These letters **must be originals** on the signator's letterhead.	_____
6.	Attach to the application a check or money order in the amount of $1,010 made payable to the Council of Certified Professional Midwifery.	_____
7.	Submit proof of current CPR certification including infant or neonatal resuscitation. A notarized photocopy of current CPR certification attached to the application will be sufficient.	_____

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Council's administrative office, in writing, immediately.

1. All application fees are non-refundable.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Council of Certified Professional Midwifery
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

For Federal Express or Special Courier:
Council of Certified Professional Midwifery
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37228

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Council asks that you please give the administrative office every consideration in this matter.

4. If necessary documentation has not been received when your application has been received by the Council's administrative office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Council's administrative office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.

5. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination and if your application is approved you will be able to view certification approval on the Internet.

6. It is recommended that you do not make arrangements to accept employment as a Certified Professional Midwife in Tennessee until you are granted certification by the Council of Certified Professional Midwifery.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have a Tennessee certificate issued by the Council of Certified Professional Midwifery in your possession before you may lawfully practice.

FOR OFFICIAL USE ONLY

ATTACH A CURRENT FULL-FACE PHOTOGRAPH

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

3045-001	**$1000**
3045-006	**$ 10**
	$1010

BOARD OF OSTEOPATHIC EXAMINATION
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APPLICATION FOR CERTIFIED PROFESSIONAL MIDWIFE IN TENNESSEE

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden

Social Security Number: ___ - ___ - ___ Date of Birth: _____

Mailing Address _____
_____
_____
Zip

Phone: Home: (___) _____ Office: (___) _____

Place of Birth: _____

Sex: (optional, for statistical purposes only)
Female ___
Male ___

U.S. Citizen: Yes ___ No ___

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space.

From: ________ To: ________ ______________________________ ____________________
Mo/Yr Mo/Yr Educational Institution Location

From: ________ To: ________ ______________________________ ____________________
Mo/Yr Mo/Yr Educational Institution Location

From: ________ To: ________ ______________________________ ____________________
Mo/Yr Mo/Yr Educational Institution Location

From: ________ To: ________ ______________________________ ____________________
Mo/Yr Mo/Yr Educational Institution Location

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES	LOCATION	POSITION AND DUTIES
From: ________ To: ________ Mo/Yr Mo/Yr	____________________ (City) (State)	____________________ ____________________
From: ________ To: ________ Mo/Yr Mo/Yr	____________________ (City) (State)	____________________ ____________________
From: ________ To: ________ Mo/Yr Mo/Yr	____________________ (City) (State)	____________________ ____________________
From: ________ To: ________ Mo/Yr Mo/Yr	____________________ (City) (State)	____________________ ____________________
From: ________ To: ________ Mo/Yr Mo/Yr	____________________ (City) (State)	____________________ ____________________
From: ________ To: ________ Mo/Yr Mo/Yr	____________________ (City) (State)	____________________ ____________________
From: ________ To: ________ Mo/Yr Mo/Yr	____________________ (City) (State)	____________________ ____________________
From: ________ To: ________ Mo/Yr Mo/Yr	____________________ (City) (State)	____________________ ____________________

LICENSURE INFORMATION

List below all states, countries, or provinces in which you have ever been or currently are licensed, permitted, or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than midwifery. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative,** attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application*.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to exercise reasoned professional judgments, to learn, and keep abreast of developments in your profession;

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devises, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?	____	____

[If you receive such ongoing treatment or participate in such a monitoring program, the Council will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued whether conditions should be imposed or whether you are not eligible for licensure.]

COMPETENCY INFORMATION continued

		YES	NO
2.	Do you currently use chemical substances?	____	____
	If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____
	Please list: _____		
	_____		
3.	Are you currently engaged in the illegal use of controlled substances?	____	____
	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	____	____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	____	____
5.	If you have ever held or applied for a license or certificate to practice as a Midwife in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	____	____
7.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	____	____
8.	Have you ever been rejected or censured by a professional society?	____	____
9.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you;	____	____
	b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	____	____
	c. Are there any legal actions pending <u>against</u> you or to which you are a party?	____	____
10.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application and signed photos attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, which were enclosed in the application packet, and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include an interview.

RELEASE to the Council and Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

AUTHORIZE the Council and Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and any other qualifications.

RELEASE from liability the Council and Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, _____.

_____
NOTARY PUBLIC

Affix Seal Here

My Commission expires _____

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

COUNCIL OF CERTIFIED PROFESSIONAL MIDWIFERY
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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you **hold or have ever held** a license to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a license or certificate to practice _____
(Profession)
numbered _____ on _____ in the State of _____.
(Date)

The Council of Certified Professional Midwifery of Tennessee requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Council of Certified Professional Midwifery.

_____
Applicant's Signature

Date _____

_____
Applicant's typed or printed name

To Be Completed By Administrative Office of State Licensure Board

Name In Full As it Appears On License/Certificate or Permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Expiration Date: _____

Basis of Issuance: _____ Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____

Is the license currently active and registered? Yes ____ No ____
Is there any derogatory information on file? Yes ____ No ____ If yes, please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

Please mail directly to: Council of Certified Professional Midwifery
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

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www.tennessee.gov

NARM VERIFICATION

Please complete this form and mail it to the address below:

Send to:

North American Registry of Midwives
P.O. Box 420
Summertown, TN 38483

To Be Completed By Applicant (Please Print In Ink)

Dear NARM Official:

I am applying for a certificate to practice as a Certified Professional Midwife in the State of Tennessee. The State Board of Osteopathic Examiners' Council of Certified Professional Midwifery requires that a credential letter be **forwarded directly to their** office by the NARM.

Applicant's Name: _____
(First) (Middle) (Last)

Social Security No.: ___ - ___ - ___ Credential # _____

_____
Signature

PLEASE MAIL CREDENTIAL VERIFICATION DIRECTLY TO:

Council of Certified Professional Midwifery
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243